Addendum 1

Application for Utilization Review (UR) and After-hours Screening/Triage/Referral

Notice to all offerors:
Should the answers to questions in this Addendum differ from the terms, conditions and specifications in the Request for Application (RFA), the answers in the Addendum shall take precedence over the original terms, conditions and specifications in the RFA.

Question 1 - Are all fields in the PA file mandatory; are there any optional fields?

Answer 1 - Yes, each field is necessary.

Question 2**:** What determines a Change Record?

Answer 2 –
REC-TYPE PIC X(01)
3.) 05 (PREF)REC-TYPE PIC X(01).
88 (PREF)REC-ADD VALUE 'A'.
88 (PREF)REC-CHANGE VALUE 'C' .
For 'REC-TYPE' (above) when is 'A' used versus 'C'?
I received in one email from the Division the following explanation. Is the following correct?
Record Type A is used to create a new PA segment having new effective dates.
Record Type C is used to modify the existing segment (cannot modify the key fields like MID, Start Date, etc).
Normally, Type C is mostly used to modify fields like End-date, Units approved, and PA Status Approved / Denied

Question 3 - Since there is a limit of 999 units on a record, if we have one for more than 999 units would that need to be a second auth with the same PA number?

Answer 3 - Yes, there would need to be an additional record with up to 999 units until the balance of the requested units has been accounted for in the authorization.

Question #4 - PA NUMBER is PIC X(13) Does this number have to be 13 in length or can it be smaller? Does it have to contain any logic, such as a Julian date or any identifying information? Can it be sequentially generated out of our software? Are there any edits on this field?

Answer 4 - Length of PA number can not be modified. There is no logic to this number. It is sequentially generated. Only edit is that all 13 characters must be 0-9.

Question 5 - Additionally will this number need to be submitted on the claims that the provider submits in the 837?

Answer 5 - No this number (PA number) will not need to be submitted on any claims (837).

Question 6 - For a non-Medicaid client if we are submitting PA's for IPRS services; what MID number should be submitted?

Answer 6 - Just to clarify: (PREF) Submittal-ID PIC X (02) should be the last 2 digits of your 34049XX number?

Question 7 - At this point "Submittal-ID" is not associated with the base provider number. It is represented as "VO".

Answer 7 - No.

Question 8 - For the SUB-SEC-CODE is the correct value still VOI and will it remain VOI?

Answer 8 – Answer will follow on Monday's Addendum II.

Question 9 - Could you clarify just a little more; the definition of the submitting billing provider number.

a. PROVIDER NUMBER PIC X(13) position 97
For example if Guilford were issuing a PA for residential H0019 and non-OBH (H000x) services that Guilford is currently billing for…**.** this would be Guilford's 3404919 number?

b. For Guilford's internal LME providers who provide OBH services, this would be our multi-specialty group number or physician group number (instead of the attending provider number of the LME employee).

c. For an outside Medicaid provider providing an OBH service, it would be their DEP enrolled number?

Answer 9 – a. Yes. b, c The billing number would be the group, the attending # would be the individual

Question 10 - And finally, the REC-ERROR-Table are values that are submitted back to us by the fiscal agent?

Answer 10 - Yes. Your file producing will (probably) stop at the field "PA-Status".

Question 11 – Are the error values the same ones that were in the Error Code .pdf file that was sent to Guilford by Eric on August 25? For example Error number 3 Error Code C would indicate that Submittal Security Code is missing?

Answer 11 - Can't verify the document that was sent on August 25,but Yes Error Code C does correspond to "Submittal Security Code is missing". Sounds like the same document, but will communicate an error code listing/translate expected error codes from EDS.

Question 12 - Also does this field start in position 145 and end at 167? The field only returns a code for an error transaction. It says in the file specifications a returned flag of "X" will denote the field within the record in error or will it return the letter from the Error Reason Code file?
For example the 1st byte = Submittal id field; the 21st byte=PA status?
So, the 22nd and 23 byte indicate according to the Error Code pdf file, 22: Hospital number is missing for High Risk Action Id/ Provider type invalid for High Risk Action Id. 23 would indicate Procedure code invalid/missing or High Risk Action Id....what does that mean?
Additionally, if one record in the file has an error only that record will not be processed? The rest of the file will be processed?

These questions relate to the Prior Authorization (PA) file specifications sheet. If conclusive answers are not currently available, I would at least need a contact or source that can provide prompt and reliable answers and clarifications.

Answer 12 - Answer will follow on Monday's Addendum II.

Field Definitions
Question 13 - SUBMITTAL-ID Will this remain the current constant value VO (stands for Value Options)? Or will it be the last two digits of the LME specific Provider Base Medicaid Number.

Answer 13 - the RFA indicates everything goes through VO as a pass through so it would be the constant value

Question 14 - ACTION-ID Need a cross walk of valid Procedure Codes to these Codes.

Answer 14 - New Medicaid Services Crosswalk 1/09//06

NEW SERVICES	CURRENT SERVICES
Ambulatory Detoxification	
Assertive Community Treatment Team – ACTT	ACTT
Community Support – Adults (MH/SA)	Case Management, CBS
Community Support – Children/Adolescents (MH/SA)	Case Management, CBS
Community Support Team – CST (MH/SA)	
Diagnostic Assessment (MH/DD/SA)	
Intensive In-Home Services	See Communication bulletin # 40
Medically Supervised or ADATC Detoxification/Crisis Stabilization	
Mental Health Day Treatment – Child/Adolescent	Day Treatment – Child
Mobile Crisis Management (MH/DD/SA)	See Communication bulletin # 48)

Multisystemic Therapy – MST	
Non-Hospital Medical Detoxification	
Opioid Treatment	Opioid Treatment
Partial Hospitalization-PH	Partial Hospitalization
Professional Treatment Services in Facility Based Crisis Program	Professional Treatment Services in Facility Based Crisis Program
Psychiatric Residential Treatment Facility – PRTF	Psychiatric Residential Treatment Facility
Psychosocial Rehabilitation – PSR	Psychosocial Rehabilitation
Substance Abuse Comprehensive Outpatient Treatment Program-SACOT	
Substance Abuse Intensive Outpatient Program-SAIOP	Substance Abuse Intensive Outpatient Program
Substance Abuse Medically Monitored Community Residential Treatment	
Substance Abuse Non-Medical Community Residential Treatment-Adult	

Question 15 - SUB-SEC-CODE Will This remain the current constant value VOI?

Answer 15 - Answer will follow on Monday's Addendum II.

Question 16 - UNITS-APPROVED currently limited to 3 characters which may not be sufficient for some services.

Answer 16 - Answer will follow on Monday's Addendum II.

Question 17 - PA-NUMBER Is this supposed to be absolutely unique for the recipient, or may the recipient have multiple Procedure Codes authorized using the same PA-NUMBER in multiple lines within the PA file? For example, PA-NUMBER 99999999999 covers one unit of 90801 and two units of 90807. There would be two lines in the PA file, both with PA-NUMBER 99999999999 and one with code 90801 and the other with 90807. Will that work, or will we have to generate a unique PA-NUMBER for each of the services?

Answer 17 - Answer will follow on Monday's Addendum II.

Question 18 - PROVIDER I understand this to be the IPRS Attending Provider Number and if there is not one this should be the State Specialty Group Number? Is there supposed to be an LME specific prefix?

Answer 18 - Answer will follow on Monday's Addendum II.

Question 19 - REFER-PROVIDER I understand this to be the LME specific Provider Base Medicaid Number.

Answer 19 - Answer will follow on Monday's Addendum II.

Question 20 - PROCEDURE-CODE 1. This is limited to 5 characters, precluding the use of modifiers. 2. Is there a possibility of a code for a "package" of like CPT services differentiated only by service duration? For example, a combination of codes 90804, 90806, and 90808.

Answer 20 - Yes a range of CPT codes for out patient services may be authorized.

Question 21 - If my cost proposal exceeds the amount noted in the RFA will my application be set aside.?

Answer 21 – No. The Divisions reserve the right not to contract with any LME if the cost proposal exceeds the amounts stated in the RFA. The Divisions reserve the right to negotiate costs when all cost proposals within the same alliance area are above the cost in the following table. The Cost Proposal should not exceed the amounts listed by alliance area in the following table.

Alliance	Active Caseload: July 2005	Medicaid Eligibles: December 2005	Maximum Bid for UR/STR Functions
Cumberland	4,571	55,731	
Johnston	3,418	25,409	
Southeastern Regional	10,446	82,361	
Southeastern Center	6,520	51,716	
Onslow-Carteret*	5,077	29,710	
Total	**30,032**	**244,927**	**4,200,000**
Smoky	8,933	35,774	
New River	4,850	27,924	
Total Population	**13,783**	**63,698**	**1,280,000**
Mecklenburg	40,828	116,273	
Pathways	9,652	71,695	
Total Population	**50,480**	**187,968**	**4,000,000**
Guilford	14,191	69,422	
Centerpoint	12,565	62,268	
Total Population	**26,756**	**131,690**	**3,000,000**
Neuse *	4,425	21,233	
Eastpointe	9,699	69,191	
Pitt	4,012	27,315	
ENWG	13,515	59,242	
Roanoke-Chowan	4,134	22,766	
Total Population	**35,785**	**199,747**	**3,000,000**
Durham	5,285	36,865	

Five County	8,101	58,783	
OPC	6,167	25,315	
Alamance-Caswell/Rockingham	8,142	45,617	
Total Population	**27,695**	**166,580**	**3,300,000**
Albemarle	3,133	22,099	
Tideland	5,654	24,541	
Total Population	**8,787**	**46,640**	**800,000**
Crossroads	4,793	40,638	
Foothills	4,994	45,545	
Catawba	2,910	24,220	
Total Population	**12,697**	**110,403**	**2,900,000****

Also (from the evaluation criteria) - Cost – Cost will be reviewed between LME applications where the LMEs are located within the same alliance. The evaluation committee will evaluate the submitted cost and cost will be used as an evaluation criteria where technical criteria a-f, above are determined to be equal. The Divisions reserve the right to negotiate prices should the maximum allowable amount for any alliance area be proposed. The maximum cost should not exceed the following amounts by alliance: (same table inserted)

Question 22 - Can I hand deliver the RFA to your office?

Answer 22 – Yes, you may hand deliver the RFA in a sealed package, clearly labeled "Utilization Review RFA Response". This package will remained sealed until opened by the evaluation committee.

Question 23 - What is the start date for Medicaid UR

Answer 23 – June 1, 2006

Question 24 - The LMEs that were awarded the S/T/R business; does that still stand? Or is it a clean slate and S/T/R is open to all 18 LMEs for reapplication like UR?

Answer 24 - Answer will follow on Monday's Addendum II.

Question 25 – Question should I submit my specific cost information in the format provided in the previous application?

Answer 25 - Yes

Question 26 - If I apply to do UR for only my LME and not the region will my application be set aside.?"

Answer 26 – RFA Instructions: **Each LME that is applying to do <u>regional</u> UR and after hours STR must submit appropriate material with this application that addresses each criterion listed below. The Application is for regional UR.**

Question 27 - Can you shed any light on 1.11 of the proposal (page 4) ? It is asking for policy related to the LMEs firewall? I think that it's asking about consumer choice – but the last phrase "constrain activities of other competing businesses (providers)" has us stumped

Answer 27 – This is not a computer firewall. This refers to the LME's divesture and or separation of direct services to recipients.